



HARVARD FXB
CENTER FOR HEALTH AND HUMAN RIGHTS



Rapid Needs Assessment in Cox's Bazar Phase I: March 2018

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INTRODUCTION

The Rohingya people of Myanmar have faced state sponsored discrimination for several decades and have been forced to flee Rakhine state to Bangladesh, Indonesia, Thailand and other countries, often following waves of violence against them (1-4). The latest exodus from Myanmar in August 2017, has resulted in an influx of over 700,000 refugees into Bangladesh, half of whom are now sheltered in camps set up around the older UNHCR-run camps in Kutupalong and Naya Para (5-7).

This sudden population expansion has strained Bangladesh's ability to respond to the crisis. Though not a signatory to the 1951 Refugee Convention, Bangladesh has historically allowed the Rohingya to stay albeit without granting them refugee status since 1992. The government is now considering several options to address the growing refugee crisis in Cox's Bazar, including repatriation, third-country resettlement, or relocation to an isolated island in the Bay of Bengal. There is growing concern that the voices of the Rohingya are not being heard while critical decisions are being made about their future. There is reported concern of growing resentment in the host communities as the Rohingya compete for resources, space, and drive down wage prices in the informal labor market (8-12).

It is against this background that the FXB Center for Health and Human Rights conducted a rapid assessment in 800 households in Ukhia and Teknaf to understand the Rohingya's priorities and needs, and the impact of their presence in the host communities. This is the first in a series of studies planned in the region to study the impact of this latest episode of forced migration in South Asia on the health, wellbeing, livelihoods, education, and rights of the vulnerable populations living in the region.

SAMPLING LOCATIONS AND POPULATIONS

Dates: March 15- March 18, 2018

Enumerators: 27

Rohingya households: 400 (across 8 camps)

Host community households: 402 (across 12 villages)

Language: Rohingya dialect; Bengali.

Software: CommcareHQ

Reporting: Daily

For further details, see fxb.harvard.edu





DEMOGRAPHICS

Households are of similar size in both the Rohingya and host community populations. However, there are a greater number of female-headed households among the Rohingya, and a greater total proportion of women.

The sampled Rohingya population had fewer men than expected and reported a greater proportion of deaths among younger men, than in the host community, consistent with the reports of violence in Myanmar, reported in the media and in other reports.

These shifting demographics among the Rohingya have significant ramifications on planning for livelihoods regenerations, self-reliance, education and skills training in the Rohingya population as they plan their future in Bangladesh or elsewhere.

EDUCATION

Education among Rohingya adults (over 15 years) was very low. Of those surveyed, 76% had never had any schooling. Since this study only sampled those who arrived after August 2017, this data is more of a reflection of the Rohingya's lack of access to education during their time in Myanmar. However, it does express a critical need for informal education and vocational training for Rohingya adults now in Bangladesh.

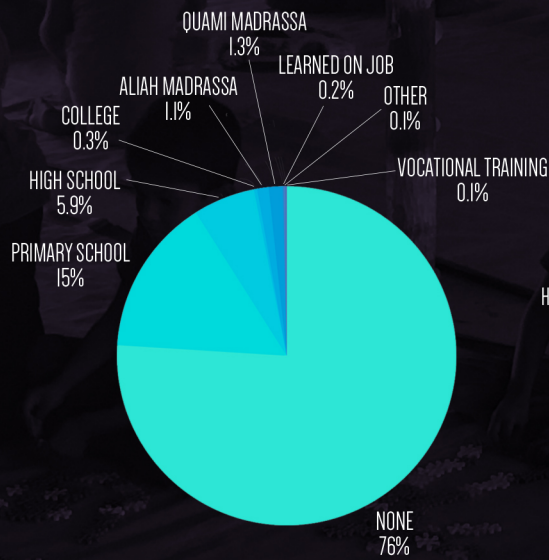
In the camps in Bangladesh, school access has been a long-standing challenge for many of the earlier arrivals, as the Rohingya have been denied access to formal refugee status, and consequently to UNHCR services. For the new Rohingya arrivals under the age of 15, 52.6% of households reported that their children were not in school. Formal schooling is already a recognized need among the response community, which is supported by the fact that 41.8% of Rohingya children receiving schooling from an NGO program, but greater access to schools is needed. Currently, BRAC provides primary level education through 200 learning centers for over 21,000 children. Additional centers are planned in the coming months.

An expansion in access to formal schooling could also benefit the local host community, as 33.6% of households reported that their children were not in school. This is further reinforced by the literature, where age-disaggregated data show that about one-third of Bangladesh's population falls in the 10-24 age group, with large gaps in basic education and employability (13, 14).

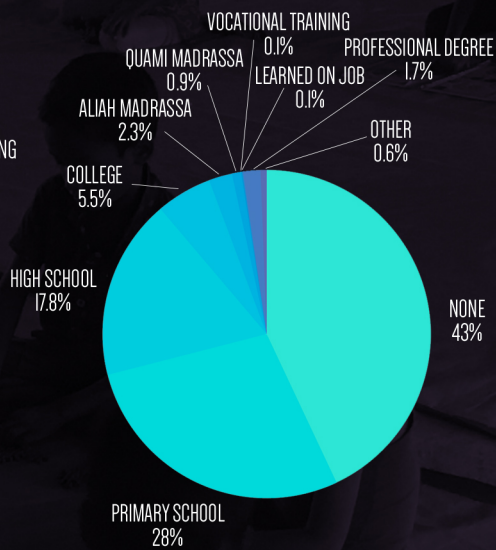
SCHEDULE OF CFS KUTUPALONG MS AGE GROUP: 2 TO 5 YEARS		
NAME OF ACTIVITY	FROM	TO
INTRODUCTION	9:00 AM	9:15 AM
RECITE POEM AND RHYME	9:16 AM	9:45 AM
PHYSICAL PLAY	9:46 AM	10:15 AM
FREE PLAY	10:16 AM	10:45 AM
GOODBYE SESSION	10:46 AM	11:00 AM
AGE GROUP: 06 TO 15 YEARS		
NAME OF ACTIVITY	FROM	TO
INTRODUCTION		

SCHOOL

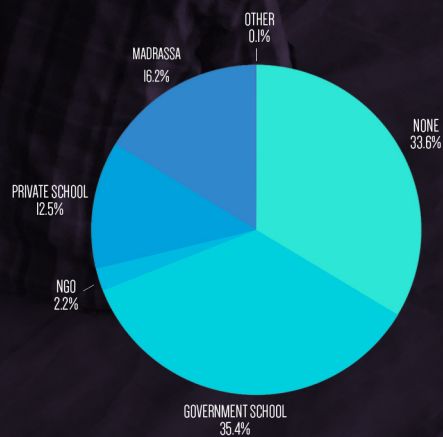
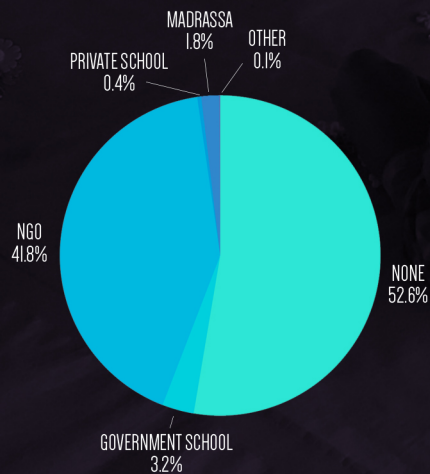
ROHINGYA



HOST COMMUNITY



ABOVE 15 YEARS OF AGE



UNDER 15 YEARS OF AGE

LIVELIHOOD AND DEBT

Due to existing employment restrictions in Bangladesh, most Rohingya households have struggled to support themselves through a regular income and are dependent on support from NGOs. Since being forced to flee Myanmar, 79.9% of Rohingya households report no current form of income in Bangladesh. While some have established income generating activities in the camp or through informal work in the host community, most Rohingya households (93.5%) reported a decrease in income over the last 12 months. Such a strain on livelihoods in Bangladesh has forced too many Rohingya households (35.8%) to fall into debt to pay for basic subsistence goods. For example, of those households that reported being in debt, the leading reason for that debt (40.2%) was to purchase food.

In the host community, where there is a fear that the recent influx of the Rohingya has driven down wages and forced local residents out of work, 49.5% of households reported a decrease in income in the last 12 months. Additionally, the mean income among local host community households decreased from 14,015 to 12,955 takas. However, this survey also identified small improvements in the local economy, such as a greater number of local households (a 9.5% increase compared to 2017) that reported earning an income. Households in the local host community reported being in debt, but the size of the debts was larger (65.8% of debts were over 20,000 takas) and the purpose was primarily for livelihoods. This reflects a greater level of formal lending to improve their standard of living, as opposed to the Rohingya households who had to borrow money to merely survive.



EFFECT ON MEAN INCOME

ROHINGYA

12151 TAKAS

IN MYANMAR



6483 TAKAS

IN BANGLADESH

HOST COMMUNITY

14015 TAKAS



12955 TAKAS



HEALTHCARE

DISEASE BURDEN

This study found that the Rohingya and the host community had similar overall disease burdens. The two populations, in fact, reported the same three most common ailments (digestive issues, hypertension and eyesight issues). However, the host community was more successful in receiving treatment for their health needs, while the Rohingya community reported similar household disease burdens, but reported receiving less treatment.

TOP 5 DISEASE BURDENS

ROHINGYA

1. DIGESTIVE ISSUES	46.3%
2. HYPERTENSION	37.3%
3. EYESIGHT ISSUES	23.1%
4. DIARRHEA	10.2%
5. WOMEN'S HEALTH	9.2%

HOST COMMUNITY

1. DIGESTIVE ISSUES	55.5%
2. HYPERTENSION	51.5%
3. EYESIGHT ISSUES	27.0%
4. DIABETES	14.2%
5. WOMEN'S HEALTH	11.5%

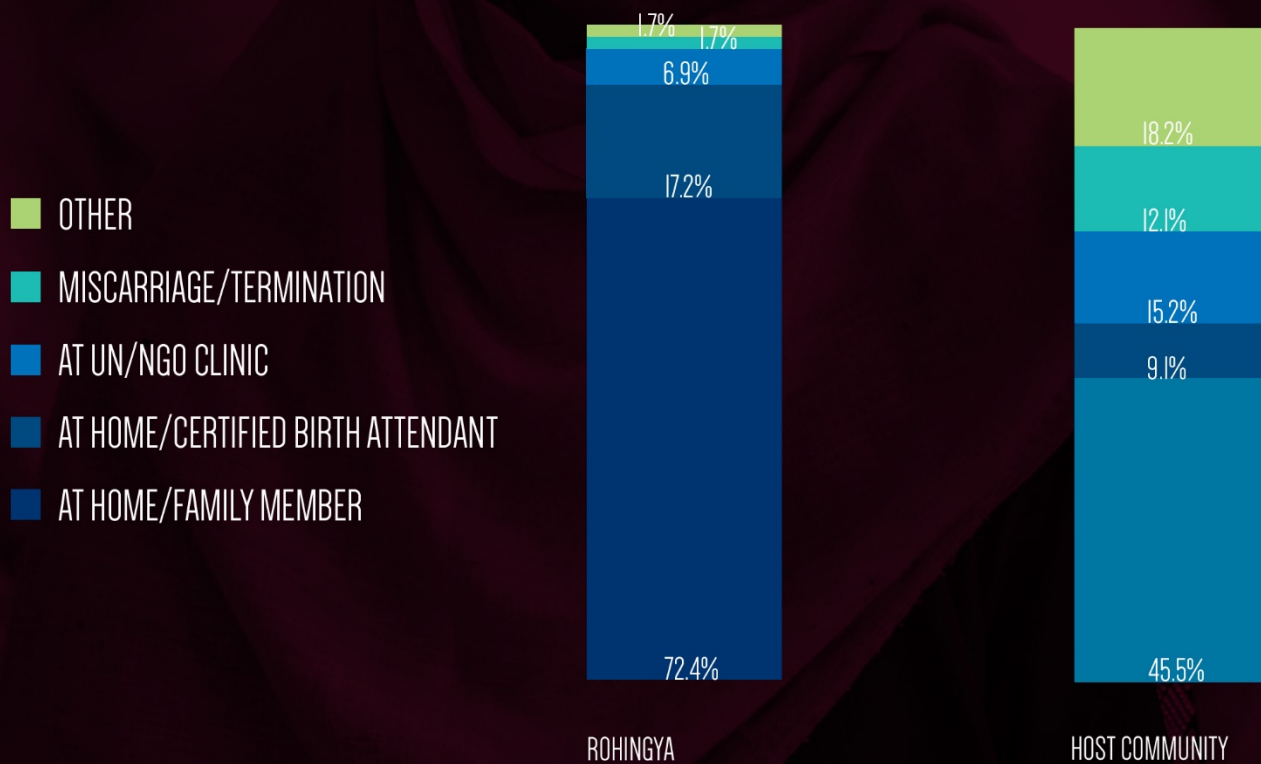


PREGNANCY AND ANTENATAL CARE

There is a clear need to prioritize access to pregnancy and antenatal services and promote outreach in the camp areas. The number of pregnancies in the Rohingya community in the past year was high, with 18.9% reporting that a woman in their household was or had been pregnant. But, of those reporting a pregnancy, most did not seem to be aware of the importance of receiving antenatal care (ANC) during their pregnancy, or of delivering in a clinic and being supervised by a certified birth attendant during delivery. The number of Rohingya women that had no antenatal visits was very high (56.6%). Additionally, most Rohingya women delivered at home without a certified birth attendant (72.4%).

The host community would also benefit from more robust pregnancy and antenatal services, as well as outreach campaigns. The number of pregnancies in the past year in the host population was much lower (11.2%). But, the need for outreach and education for safe pregnancies was evident. The number of women who reported having no ANC visits (33.3%) and delivering at home without a certified birth attendant (45.5%), while each far lower than the Rohingya community, was still relatively high.

DELIVERY LOCATION



VACCINES

The vaccination schedule for Bangladesh, recommends at least nine doses of vaccines (including Hepatitis, DTaP, MMR, PCV, and Meningococcal vaccines, among others) by the age of two. (15).

This study found that the vaccination rate in Myanmar was alarmingly low. More than half of all children had received no vaccines. The recent diphtheria epidemic in Myanmar reflects a clear connection to this study's data and the institutionalized discrimination inflicted upon this population by the Burmese government. The vaccination campaigns in Bangladesh among the Rohingya, however, seemed to have very good penetration, reaching 88.2% of the 314 Rohingya children in our sample.

Additional studies are urgently required on the types and timing of vaccines given. There is need to strengthen systems that allow the population access to their vaccination records, as they move from camp to camp or migrate elsewhere.

HEALTHCARE ACCESS

This survey identified a clear need to improve access to health services within the host community. Of those surveyed, 32.7% in the host community reported issues with healthcare access. Distance was the main difficulty cited by host community households (58.6% of those reporting challenges), which suggests that programs that employ mobile clinics or community health workers to reach remote areas could help improve utilization.

In the Rohingya community, challenges to health access were not as severe (14.2% reported having issues). This outcome is likely due to the NGO penetration in health services that exists in the camps. However, like the local host community, distance was also the leading reason (50.7%) for lack of access of those Rohingya reporting challenges.

Lack of ability to pay was also a top reason given among both groups; 29.9% among the host community and 10.1% among the Rohingya said that they could not afford care. The issue of affordability also surfaces in the issue of debt, as both groups reported borrowing money to pay for healthcare.

VACCINATIONS

CHILDREN TWO YEARS AND YOUNGER

ROHINGYA

61.7% RECEIVED NO INJECTABLE VACCINES IN MYANMAR

57.5% RECEIVED NO ORAL VACCINES IN MYANMAR

187 CHILDREN SAMPLED

HOST COMMUNITY

4.8% RECEIVED NO INJECTABLE VACCINES IN BANGLADESH

11.9% RECEIVED NO ORAL VACCINES IN BANGLADESH

84 CHILDREN SAMPLED



WATER AND FOOD

WATER SOURCE AND PURIFICATION

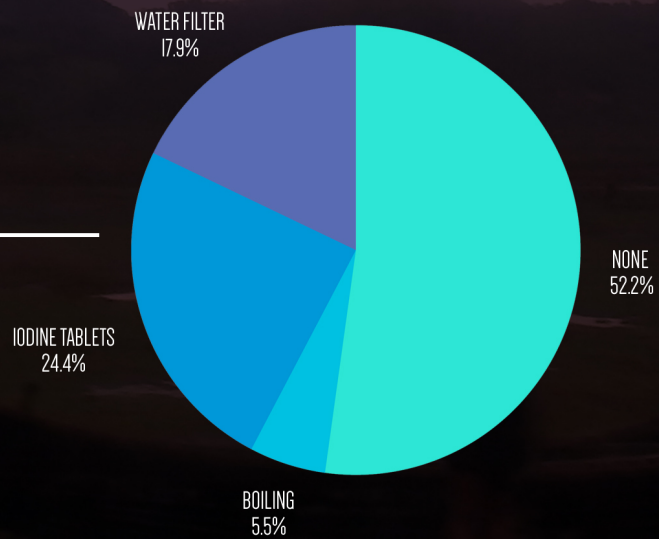
There were no reported deficits in access to water among the Rohingya and host community households. Most of the host community households (90.8%) and over half of the Rohingya households (52.2%) did not purify their water, with other Rohingya households opting to use iodine tablets (24.4%) or water filters (17.9%). The majority of households in both the Rohingya (88.6%) and host community (79.3%) used tube wells to procure water for drinking, cooking, and bathing. Tube wells, if not contaminated at the source, supply water safe for use without the need for purification

FOOD SECURITY

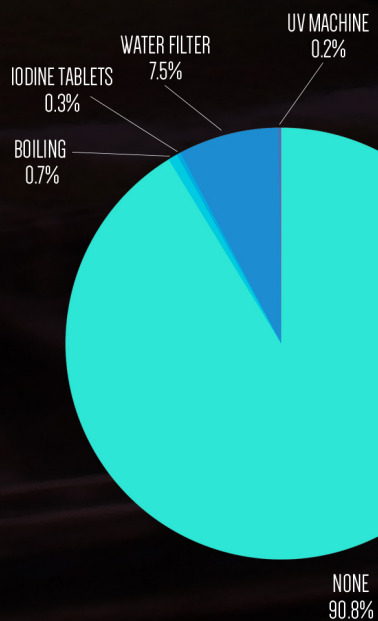
The recently-arrived Rohingya population is reliant on humanitarian assistance for food. Food vouchers are distributed by WFP that may be exchanged for a selection of food items (16). However, there was a high level of food insecurity among the Rohingya population, with a third of the Rohingya households having two meals a day (35.8%). Of the households that ate three meals a day (62.9%), 32.7% reported a food shortage. Provision of cash assistance may allow the Rohingya to access a more diverse offering of foods while giving them the independence to prioritize their expenses (17).

WATER PURIFICATION METHODS

ROHINGYA



HOST COMMUNITY



SHELTER

As of March 2018, 45.5% of the Rohingya were living in tents. The remaining non-tent homes were primarily made of tarpal roofs (83.6% of all non-tent homes), and walls made of tarpal (44.3%), plastic (32.9%) or bamboo (21.9%). Almost no host community households were in tents (1.5%), with most of the host roofs made from other materials like tin (71.6%), and thatch walls (45.7%). The lack of structural integrity of these homes brings forward an immediate need for adequate shelter and risk mitigation, especially as the severe monsoon season from June to October approaches Bangladesh (18).



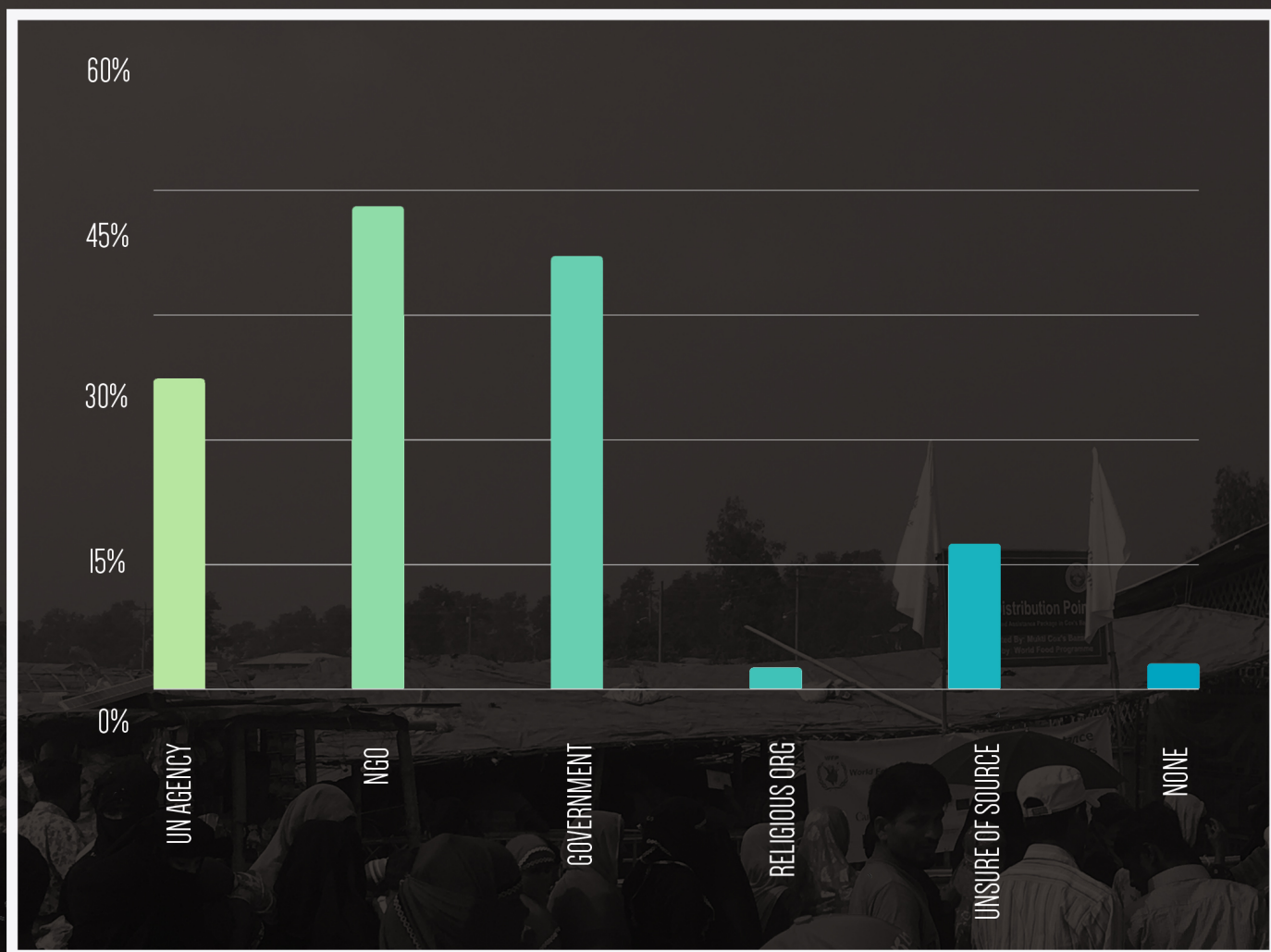


DONOR AID/NEEDS MISMATCH AND CASH ASSISTANCE

The lack of income for most households in the Rohingya community necessitates a robust response to meet the humanitarian need. Even the most basic items, such as blankets, cooking utensils, and other non-food items (NFI) are in great need since Rohingya families were only able to take what they could carry when fleeing their homes in Myanmar. The majority of Rohingya (97.0%) say they are receiving NFIs from various sources, and sometimes multiple sources. The most common sources are NGOs and the government. Of those that reported receiving aid from NGOs, 48.5% reported receiving aid from BRAC.

The Bangladesh government and NGO partners are striving to ensure that the humanitarian response is reaching those most in need. Although most (63.4%) of the Rohingya feel that resources are being allocated appropriately, slightly over a third (36.6%) do not. The feasibility of cash-based interventions is being considered in various settings, such as food security and protection. When Rohingya participants were asked about how they would spend an extra 15,000 takas, the most common response was food, followed by livelihood (business/livestock), and shelter. In contrast, the most commonly cited way an extra 15,000 takas would be used by the host community would be for livelihood (39.0%) followed by food, and shelter.

SOURCE OF NFIs RECEIVED



ROHINGYA

SAFETY AND CONDITIONS

Given the dense overcrowding of the camp areas, Rohingya households face several protection concerns. The Government of Bangladesh and NGOs are coordinating to mainstream protection into humanitarian services, including a prioritization of the most vulnerable (women, children, and those in greatest socio-economic need). The vast majority of Rohingya community members participating in this study did report feeling safe (93%). Of those who did not feel safe, 9.1% said that they feared physical or sexual assault. Generally, among the Rohingya, the main reason given for not feeling safe was that they fear repatriation; 59.0% of those who said they do not feel safe gave this as one of their reasons.

In the host community, tensions with the Rohingya community were evident. Among the host community members who reported not feeling safe, the main reason given was that they fear the Rohingya (64.7% of those who do not feel safe gave this as the reason). Efforts to mitigate the tension between communities, through greater dissemination of information and increased inter-communal dialogue, should continue.

The majority in both communities say they trust the police and military (90.0% of Rohingya and 81.8% of the host community). However, despite the majority saying they trust the police and military, both groups say they would hesitate to go to the police if they had a grievance. Only 20.1% of Rohingya say they would go to the police with a grievance (71.9% say they would not and 8.0% were not sure). The local host community had a slightly better level of comfort in going to the police with a grievance (45.0%); however, 53.0% did say they would not go to the police (2.0% were not sure).

Communicating with communities (CwC) is a critical component of the humanitarian response. The ability to communicate messages regarding the availability of services and how to access them is key to effective implementation. Moreover, successful engagement with the Rohingya community also requires providing them a voice and receiving feedback regarding community concerns. In an effort to better inform these communication channels, this study investigated the manner in which Rohingya households received information and who they felt best represented their interests. Not surprisingly, the majority of Rohingya participants (94.7%) said that camp leaders represented their voice. Sources of news for the Rohingya were varied, but the majority of households said that their news and information primarily comes via word of mouth (61.5% for the Rohingya).

SAFETY

FEEL SAFE

93%

ROHINGYA

92%

HOST COMMUNITY

TRUST MILITARY & POLICE

90%

ROHINGYA

81.8%

HOST COMMUNITY

RECOMMENDATIONS

The following recommendations are based on information gleaned from the survey results.

Education

- BRAC and other providers should implement current plans to expand the number of primary level learning centers in the Rohingya camps and in the local host communities. This expansion should be supported by outreach and awareness campaigns.
- Increase the level of access for informal education and vocational training for adults in both the Rohingya and host communities.

Livelihoods / Assistance

- Establish greater opportunities for income generating activities in the camp and in the host community. Special focus should be made for vulnerable groups, such as women and people with disabilities.
- Increase opportunities for cash-based interventions to help Rohingya families address basic needs for staple goods.
- Expand opportunities for formal lending to help host community livelihoods thrive.

Health

- Expand access to primary health services, as well as ANC and delivery services. This expansion should be supported by outreach and awareness campaigns.
- Prioritize leading health issues based on the survey data (digestive issues, hypertension and eyesight issues, diabetes, women's health).
- Promote awareness campaigns for vaccinations in the Rohingya camps to increase the rate of coverage.

Water / Food

- Based on rates of diarrhea and other water-borne ailments, there is little evidence that water contamination is currently a problem in both communities. However, with low rates of water purification in both communities and the potential for flooding from monsoons in the near future, this issue should be monitored.
- Increase opportunities for cash-based interventions to help Rohingya families address basic needs for food items.

Shelter

- Improve living condition and shelters for Rohingya households in advance of the upcoming monsoon season. Prioritize the 45.5% of Rohingya currently living in tents.

Safety / Protection

- Increase CwC programs to expand access to information and improve inter-communal relations. Involve police and local authorities in dialogue to build trust and improve engagement.

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